Welcome to FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS!

Our mission is to educate and empower families in our community toward true wellness and help them achieve optimal health, healing, and performance through natural and gentle chiropractic care.

PATIENT INFORMATION

Child's Name_____ Today's Date _____

Nickname_____ Parent(s) Names _____

Parent: Home Phone (___) _____Cell Phone (____) _____ Work Phone (___) _____

Street Address_____ City _____ State_____ Zip _____

Age _____ Date of Birth _____ Social Security # _____Height _____ Weight _____

Pediatrician / Other Professionals Visited: _____

REASON FOR SEEKING CARE

In order to best serve your child, it is important to know what your goals are for them. Please check all that apply to your child:

__Maximum Correction of the Problem __Improved Focus and Concentration __ Better Sleep
__Healthy Growth and Development __Prevention of Future Problems __Improved Performance
__Decreased Reliance on Medications __Improved Posture and Flexibility __Stronger Immunity
__Symptom / Temporary Relief Only __Overall Wellness (maximum expression of health)
__Other:_____

Interference to normal function can cause many different signs and symptoms. Our goal is to determine if SUBLUXATIONS (areas of neurospinal stress) are playing a role in your child's current level of health. Please indicate if your child has been affected by any of the following health challenges:

___ Ear Infections ___ Scoliosis ___ Seizures ___ Chronic Colds
___ Asthma ___ Allergies ___ Digestive Problems ___ ADHD
___ Recurrent Fevers ___ Colic ___ Bed Wetting ___ Headaches
___ Sleeping Problems ___ Growing Pains ___ Accident ___ Motor Problems
___ Neck Problems ___ Back Problems ___ Other:_____

HEALTH, WELLNESS, AND CHIROPRACTIC CARE

The following questions will give us a profile of the specific stresses your child has faced in his / her lifetime. Physical, emotional and chemical stresses can accumulate over time and result in a *serious loss of health potential*. Often, the effects are gradual and may linger for years without any signs and symptoms. Learning about these stresses will help us to better understand their current level of health.

PREGNANCY, LABOR, AND DELIVERY HISTORY

Location of Birth (*please circle*): Home / Birthing Center / Hospital / Other: _____

3rd Trimester Presentation: Vertex / Breech / Transverse / Facial / Brow

Type of Birth: Vaginal / Forceps / Cesarean / Vacuum / Suction

List any congenital anomalies / birth defects _____

HISTORY OF CHEMICAL STRESS

Infant Feeding: Breast / Bottle If bottle, which formula? _____

From the time of conception, was your child exposed to any second hand smoke? YES / NO

During pregnancy, did mother consume any alcohol? YES / NO Cigarettes? YES / NO

Does your child consume fast food: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume soda: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume fruit juices: Daily / Weekly / Bi-Weekly / Monthly / Never

Does your child consume processed foods: Daily / Weekly / Bi-Weekly / Monthly / Never

Number of antibiotics in last 6 months: _____ Lifetime: _____

Number of Vaccines in Lifetime: _____ Any Adverse Reactions to Vaccines: YES / NO

List Any Prescription or OTC Medications in last 12 months: _____

_____

HISTORY OF EMOTIONAL / PSYCHOLOGICAL STRESS

Have you noticed any behavioral problems? _____

# of hours your child sleeps during day: _____Night: _____ Rate their quality of sleep: Poor / Fair / Good / Excellent

Number of hours daily spent at TV, computer, or playing video games: _____

Does your child have difficulty socializing? _____

Does your child have difficulty concentrating? _____

HISTORY OF PHYSICAL STRESS

Any signs of birth trauma? _____

List any surgeries or hospital visits: _____

What sports does your child participate in? _____

List any sports-related injuries: _____

List any falls from cribs, changing tables, high chairs, stairs, etc: _____

Any car accidents: _____

Weight of your child's backpack: _____ Any other physical traumas: _____

FINANCIAL INFORMATION *(PLEASE READ AND SIGN BELOW)*

I understand and agree that I am responsible for payment in full for all services rendered on the FIRST VISIT.

I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. It is understood and agreed that the amount paid for x-rays is for examination only and that the films are the property of the office and are on file where they may be seen at any time while my child is an active patient in this office. I may obtain copies of their file upon request. Copying fees may apply.

I agree that this information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

(Parent / Legal Guardian)

Finger Lakes Family Chiropractic & Wellness

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Pregnancy Release *(For All Females)*:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

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Notice of Privacy Practices (HIPAA)

Effective Date: This notice is in effect as of November 1, 2007

Acknowledgement: *I have been offered to review a copy of the "Notice of Privacy Practices" of Finger Lakes Family Chiropractic & Wellness.*

Name (Print)	Signature	Date

Signature of Personal Representative, Relationship	Date

Witness	Date